

✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4B

09255

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:

County St. MarysCity or town Charlotte Hall
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Braxton4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife Jeanette ShusterFeb 8, 1882 6. (c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 63 Months 7 Days 11 If less than one day hrs. min.9. Birthplace Charlotte Hall Md.
(Town, county, and state)10. Usual occupation Janitor

11. Industry or business

12. Name William Braxton13. Birthplace Va.14. Maiden name Lorraine West15. Birthplace St. Marys16. Informant Jeanette BraxtonAddress Charlotte Hall17. Burial Date thereof 9-23-45
(Burial, cremation, or removal. Which?) Burial (month) (day) (year)Cemetery or crematory Mt. CalvaryLocation St. Marys Co.18. Funeral director Elmer M. GudeAddress Hughesville, Md.19. 9/20 1945: Julia H. Pasey
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County St. MarysCity or town Charlotte Hall
(If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 19 19 45 at 6 P.M.21. I CERTIFY that death occurred on the date above stated; that deceased from 6/12/45 19 45 to 7/20/45 19 45and that I last saw h. alive on 7/18/45 19 45Immediate cause of death Corditis Compaction DURATIONArterial ThrombosisEsophageal Heart BlockDue to Corditis Compaction

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

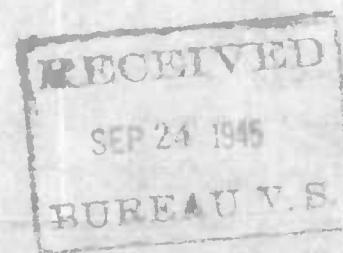
Accident, suicide, or homicide... Date of ...

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Daniel S. Fisher M. D. or other _____Address Hughesville Date signed 9/20/45



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

0925

CERTIFICATE OF DEATH

Reg. Dist. No.

282

1. PLACE OF DEATH:

County Chesapeake Bay Md

City or town (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or Inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

3. (a) FULL NAME

MARY ELIZABETH COWAN

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Single

6. (b) Name of husband or wife

Tanner

7. Birth date of deceased (mo., day, yr.)

Sept. 28 - 1916

8. AGE:

Years

Months

Days

If less than one day

28 | 11 | 20 | hrs. min.

9. Birthplace

China Grove N.C.

(Town, county, and state)

10. Usual occupation

Clark

11. Industry or business

War Dept.

MOTHER FATHER

Tanner Sidney Cowan

13. Birthplace

China Grove N.C.

14. Maiden name

Mary J. Cooper

15. Birthplace

Woburnville N.C.

16. Informant

Virginia O Bradshaw

Address 172 S. Prospect Lenoir

17. Removal (Burial, cremation, or removal. Which?) Date thereof

Cremated 8/15/45 (month) (day) (year)

Cemetery or crematory Wash. D.C.

Location

W. W. Chambers Rd.

Address 3072 M. at. & W. D.C.

18. Funeral director W. W. Chambers Rd.

Address 3072 M. at. & W. D.C.

19. 9/12 1945 Cremated (Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia

County Arlington

City or town (If outside city or town limits, write RURAL NEAR and give town)

Street No. 5701 - 11th Rd. No. Arlington

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 8th 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw h alive on 07/12/45 1945

Immediate cause of death Accidental DURATION

Due to drowning

having slipped and fallen over board

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings:

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 8/15/45

Where did injury occur? Chesapeake Bay (City or town) (County) (State) Md.

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work? Vacant

Signature Francis F. Greenwell, M.D. or other

Address 100 E. Main Street (City or town) (County) (State) Va.

Date signed 9-12-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12)

CERTIFICATE OF DEATH

09251 *

Reg. Dist. No.

1. PLACE OF DEATH:

County.....

City or town.....

Chesapeake Bay Md
St Mary's Co

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

EMMETT F. GOODEY

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Married

6. (b) Name of husband or wife.....

Bettie F. Goodey

7. Birth date of deceased (mo., day, yr.)

Oct 7th 1908

(b.c) If alive, give age

years

8. AGE:

Years
36

Months

Days

If less than one day

hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Physician (Chiropractic)

11. Industry or business

Self

12. Name.....

unknown

13. Birthplace.....

(1)

14. Maiden name.....

unknown

15. Birthplace.....

(1)

16. Informant.....

Mrs Irene Brill

Address

1910 C. St. N.E.

17. Removal.....

(Burial, cremation, or removal. Which?)

Date thereof.....

(month) (day) (year)
8/12/45

Cemetery or crematory.....

Location.....

W. W. Chambers Av

18. Funeral director.....

W. W. Chambers Co

Address

3072 M. St. N.W. D.C.

19. Date rec'd by registrar

1945

Canalier

Registrar

3. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Virginia

County..... Arlington

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 1302 Lee Highway

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH..... Sep 8th 1945 at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I examined deceased from

19..... to 1945 Sept 12 1945

and that I last saw him alive on 19..... 19.....

Immediate cause of death..... Accidental

DURATION

Following

Due to..... Effect to save a drowning

Due to..... Complicated

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Accident Date of 9-8-45

Where did injury occur?..... Chesapeake Bay (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury.....

Injured at work? Yes/No

23. SIGNATURE.....

M. D. or other

Address..... Forest Street, D.C. Date signed Jan 12 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

CERTIFICATE OF DEATH

09258

Reg. Dist. No. 286

1. PLACE OF DEATH:

County

City or town

St. Mary's
Towson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

11 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Charles Henry Taft

4. Sex

5. Color or race

6. (n) Single, married, widowed, or divorced

m white single.

6. (b) Name of husband or wife

7. Birth date of deceased (mo. day, yr.)

8. (c) If alive, give age years

2 - 1 - 1931

8. AGE:

Years

Months

Days

If less than one day

14 2 9 hrs. min.

9. Birthplace

Wilmington Del

(Town, county, and state)

10. Usual occupation

Schoolboy

11. Industry or business

FATHER

John William Taft

12. Name

Charles

13. Birthplace

Sacred Heart

14. Maiden name

Gladys Lee Cheselden

15. Birthplace

Towson Md

16. Informant

John W. Taft

Address

Berkmar Rd.

17. Burial

Sacred Heart

(Burial, cremation, or Removal. Which?)

Date thereof 9-12-48

(month) (day) (year)

Cemetery or crematory

Sacred Heart

Location

Berkmar Rd

18. Funeral director

M.C. in charge

Address

Lowell

19. Date rec'd by registrar

19-4-2 R.V. Palmer

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

St. Mary's

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

9-10

1948

at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him dead on 1948 at 1948

Immediate cause of death

accidental

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

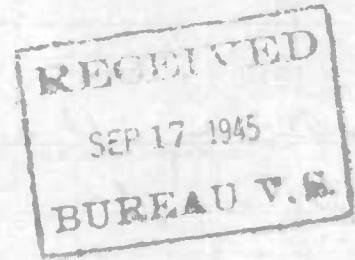
23. SIGNATURE

Robert V. Palmer

M. D. or other

Address

avon rd. Date signed 8-11-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09259

282

Reg. Dist. No.....

1. PLACE OF DEATH:

County.....

City or town.....*St. Marys*
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....*40 years*

Hospital, institution, or street address where death occurred: _____

How long in hospital or institution?.....

3. (a) FULL NAME

Elvina Lucretia Bowles Heff

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

*F**W**widowed*6. (b) Name of husband or wife.....*J. M. Heff*

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age.....years

Aug 8 1881

8. AGE:

Years
*64*Months
*1*Days
*16*If less than one day
hrs. min.

9. Birthplace.....

Louisville St. Marys Md
(Town, county, and state)

10. Usual occupation.....

Hairress wife

11. Industry or business

MOTHER FATHER

12. Name.....*Daniel J. Bowles*

13. Birthplace

*St. Marys Co*14. Maiden name.....*Mary Alice Graves*

15. Birthplace

*St. Marys Co*16. Informant.....*Mrs. Edith Goldsborough*

Address

Hallie Wood Md

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof.....*Sept 26 1945*
(month) (day) (year)

Cemetery or crematory

St. John's Cemetery

Location

*Hallie Wood Md*18. Funeral director.....*W. C. Mattison & Sons*

Address

Leonardtown Md

19. Date rec'd by registrar

19

Sept 29 1945 Casualty

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Maryland*County.....*St. Marys*City or town.....*Melvin Neck*

Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.....*Leonardtown Md*

Rte. #1

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2d. DATE OF DEATH.....*Sept 23 1945* at *4:00 P.M.*21. I CERTIFY that death occurred on the date above stated: that I attended deceased from *Sept 23 1945* to *Sept 23 1945*.and that I last saw him alive on *Sept 23 1945*.Immediate cause of death.....*Cerebral injuries*Due to.....*Fractured skull*Due to.....*Automobile accident; Queen*
on September 23rd 1945

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....*Accident* Date of *Sept 23 1945*Where did injury occur? *1/2 mile south of Leonardtown Md* Route 5
(City or town) (County) (State)Injured at home, farm, industry, public place (where)? *Public place*

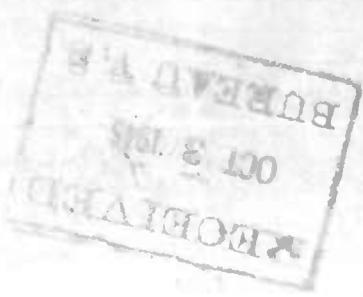
Means of injury automobile accident Injured at work?

23. SIGNATURE

J. Greenwell Coroner

M. D. or other

Address.....*Leonardtown Md* Date signed *Sept 24 1945*



M PLEASE WRITE PLAINLY, WITH UNFADING INK
C Supply every item of information carefully. The correct age
 is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

09260

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:
 County St. Marys
 City or town USNAS Disp. Patuxent River, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 1/2 months
 Hospital, Institution, or street address where death occurred:
USNAS Disp. Patuxent River, Md.
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
 State Maryland County St. Marys
 City or town California
(If outside city or town limits, write RURAL and give nearest town)
 Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war?

3. (a) FULL NAME
William Joseph Luczak Jr.

4. Sex <u>M</u>	5. Color or race <u>W</u>	6.(a) Single, married, widowed, or divorced <u>Single</u>
-----------------	---------------------------	---

6.(b) Name of husband or wife _____

7. Birth date of deceased (mo. day, yr.) 9 July 1945

8. AGE: Years <u>---</u>	Months <u>2</u>	Days <u>12</u>	If less than one day ---.hrs. ---.min.
--------------------------	-----------------	----------------	---

9. Birthplace St Marys, Md.
(Town, county, and state)

10. Usual occupation: _____

11. Industry or business: _____

MOTHER FATHER
 12. Name William Joseph Luczak
 13. Birthplace Houston, Texas

MOTHER
 14. Maiden name Leona Dorothy Miller
 15. Birthplace Texas

16. Informant William J. Luczak
 Address USNAS, Patuxent River, Md.

17. Burial Burial Date thereof 9/23/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Alloysius
 Location Leonardtown

18. Funeral director B. Robinson
 Address Leonardtown

19. 8/22/3 1945
(Date rec'd by registrar)

Registrar

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 21 September 1945 at 2100 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
21 September 1945 to 21 September 1945
 and that I last saw him alive on 21 September 1945

Immediate cause of death ENTERITIS, Acute DURATION
4 Days

Due to: _____

Due to: _____

Other conditions: _____
(Include pregnancy within 3 months of death)

Major findings of operations: _____ Date of op. _____

Autopsy results: _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: _____ Date of: _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Richard H. Driscoll
 M. D. or other
 USNAS Dispensary
 Patuxent River, Md. Date signed 9-21-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 27

09261

CERTIFICATE OF DEATH

Reg. Dlat. No. 281

1. PLACE OF DEATH:

County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 10 years
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

3. (a) FULL NAME

Eliza Jane Wilson

4. Sex..... 5. Color or race..... 6. (a) Single, married, widowed, or divorced

Female..... Colored..... Widowed.....

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)..... Feb. 25 1865
6. (c) If alive, give age..... years

8. AGE: Years..... Months..... Days..... If less than one day
80 8 4

9. Birthplace..... Piney Point, St. Marys, Md.
(Town, county, and state)

10. Usual occupation..... Housewife

11. Industry or business

FATHER: 12. Name..... John Birse
13. Birthplace..... St. Marys Co. Md.

MOTHER: 14. Maiden name..... Mary (Cumbrown) Birse
15. Birthplace..... St. Marys Co. Md.

16. Informant..... Jessie Wilson ~~29~~
Address..... 21 F. st N.W. Wash. D.C.

17. Burial..... Date thereof..... Sept. 15, 1945
(Burial, cremation, or removal. Which?)

Cemetery or crematory..... St. Georges
Location..... near Valley Lee, Md.

18. Funeral director..... W.C. Mattingley Sons
Address..... Leonardtown, Md.

19. Date rec'd by registrar..... Sept. 14 1945
(Date rec'd by registrar)..... P.J. Beary, M.D.
Local Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... St. Marys

City or town..... Piney Point
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH..... Sept. 15, 1945 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 1944 to Sept. 10, 1945 and that I last saw her alive on Sept. 10, 1945.

Immediate cause of death..... General Arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Includes pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

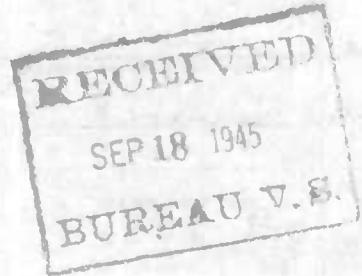
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... P.J. Beary, M.D. M. D. or other

Address..... Great Mills, Md. Date signed 9-14-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(72)*

69262

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County..... St. Marys
 City or town..... Wynn, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Harry A. Myers

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife..... Margaret

7. Birth date of deceased (mo., day, yr.) June 2 1907

8. AGE:	Years	Months	Days	If less than one day
	38		 hrs. min.

9. Birthplace..... West Virginia
(Town, county, and state)

10. Usual occupation..... pipe fitter

11. Industry or business

FATHER	12. Name..... Jeremiah Myers
	13. Birthplace..... West Virginia

MOTHER	14. Maiden name..... Mary Bennett
	15. Birthplace..... West Virginia

16. Informant..... Margaret Myers

Address..... Wynn, Maryland

17. Burial Date thereof..... 9/7/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Michaels

Location..... Ridge, Maryland

18. Funeral director..... P. B. Robinson

Address..... Leonardtown, Md.

19. 9/6 1945 Casualty Date rec'd by registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State..... Maryland County..... St. Marys
 City or town..... Wynn, Maryland
(If outside city or town limits, write RURAL and give nearest town)
 Street No.....
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 1945 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
on 9/4 1945 to *19*
 and that I last saw him alive on *19*

Immediate cause of death..... *Cardiac dilation of heart acute*

DURATION

Due to..... *over in the garage at home*

4 weeks

Due to..... *over in the garage at home*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

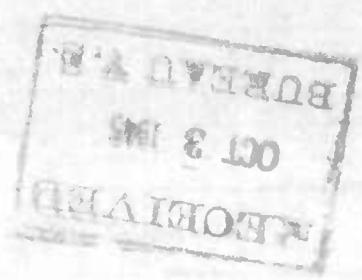
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE..... F. P. Greenwell M. D. or other

Address..... Leonardtown, Md. Date signed..... 9-5-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *(Handwritten)*

09263

CERTIFICATE OF DEATH

Reg. Dist. No. 282

1. PLACE OF DEATH:

County St. Mary's

City or town Patuxent River, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

NAS Dispensary, Patuxent River, Maryland

How long in hospital or institution? Born 25 Sept. 1945

3. (a) FULL NAME

SMILEY, Baby John Ray III

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Single

B. (b) Name of husband or wife.

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 25, 1945

8. AGE: Years Months Days If less than one day
2 hrs. min.

9. Birthplace Patuxent River, Maryland

(Town, county, and state)

10. Usual occupation Yeoman first class

11. Industry or business U. S. Navy

12. Name SMILEY, John Ray

13. Birthplace Port Huron, Michigan

14. Maiden name Betty Louise Wray

15. Birthplace Huntington, West Virginia

16. Informant Father: John Ray Smiley

Address US NAS, Patuxent River, Maryland

17. Removal Cremation Date thereof 27 Sept. 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Robinson's Funeral Home

Location Leonardtown, Maryland Washington, D.C.

18. Funeral director J. B. Robinson

Address Leonardtown, Md.

19. 9/25/45 1945 Cremation
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Mary's

City or town Patuxent River, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. M.E.M.Q. #708c

(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH 27 September 1945 at 1:57 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1945 to Sept. 26 1945

and that I last saw him alive on Sept. 26 1945

Immediate cause of death.

Intracranial injury

DURATION

2 days

Due to.

Due to.

Other conditions.

(Include pregnancy within 3 months of death)

Major findings of operations.

Date of op.

Autopsy results.

Not done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE HOWARD ROYER Lt. Comdr. (MC) USNR

M. D. or other

Address US NAS, Patuxent River, Md. signed 9-27-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

19264*

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CERTIFICATE OF DEATH

Reg. Dia. No.

1. PLACE OF DEATH:

County.....

St. Marys

City or town.....

Compton

Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

1 day

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

Felix Albert Somerville

4. Sex

5. Color or race

6. (c) Single, married, widowed, or divorced

Male

colored

married

6. (b) Name of husband or wife.....

Mary Elmera Somerville

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age

years

May 15 1895

8. AGE:

Year

Months

Days

If less than one day

50

3

25

hrs.

min.

9. Birthplace.....

Compton St. Mary's Co Md

(Town, county, and state)

10. Usual occupation.....

Laborer Boat building

11. Industry or business.....

Captain

FATHER

12. Name.....

Thomas Somerville

13. Birthplace.....

St. Marys Co

MOTHER

14. Maiden name.....

Lina Corrubs

15. Birthplace.....

St. Mary's Co

16. Informant.....

Mary Elmera Somerville

Address.....

Compton Md

17. Burial.....

Burial

Date thereof.....

Sept 11 1945

(month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory.....

St. Francis Xavier Cemetery

Location.....

Compton Md

18. Funeral director.....

W C. Mathay Legg Sons

Address.....

Leonardtown Md

19. Date rec'd by registrar.....

Oct 1 1945

Cause.....

Cause

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

St. Marys

City or town.....

Compton

County.....

St. Marys

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Sept 9 1945 at 12:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19.

on 9-9-45 1946

and that I last saw him alive on

Immediate cause of death.....

Crashed Auto

DURATION

Due to.....

Collision with Automobile

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Accident Date of 9-9-45

Where did injury occur? near Compton St. Marys Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Public road

Means of injury Hit by automobile Injured at work? no

7-7-45

23. SIGNATURE

F. J. Greenwell M.D. or other

Address..... Date signed.....

